

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8

CERTIFICATE OF DEATH

12652
Reg. Dist. No. 253

1. PLACE OF DEATH:

County

City or town

Glen Anne
Stevensville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ida M. Bright

4. Sex

7 W Widowed

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

James B. Bright

7. Birth date of deceased (mo., day, yr.)

Jan 2 - 1863

8. (c) If alive, give age

years

8. AGE:

82 Years Months Days If less than one day
hrs. min.

9. Birthplace

Stevensville

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

—

12. Name

—

13. Birthplace

—

14. Maiden name

M. Jane Walker

15. Birthplace

Glen Anne

16. Informant

Mrs. Geo. Benton

—

Address

Stevensville, Md.

Burial

Date thereof Dec 29 45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Stevensville, Md.

Location

Stevensville, Md.

18. Funeral director

Sister of Jane

Address

Church Hill Md.

19. L 5

(Date rec'd by registrar)

19 45

(Date)

C. Thomas

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. Stevensville

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1945, at 11 P.M.

21. CERTIFY that death occurred on the date above stated: the intended deceased from

May 1 1937 to Dec. 27 1945.

and that I last saw her alive on Dec. 27 1945.

Immediate cause of death

Paroxysm of disease
(Paroxysm agitans)

DURATION

about 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

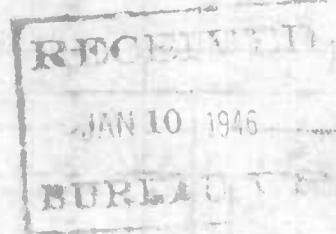
Injured at work?

23. SIGNATURE

Thomas Latellman M.D.

M. D. or other

Address Stevensville Date signed 12/27/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45

CERTIFICATE OF DEATH

12653
Reg. Dlat. No. 253

1. PLACE OF DEATH: Queen Anne's
County.....
City or town..... Love Point
(If outside city or town limits, write RURAL and give nearest town) 4 years
How long in above place of death?.....
Hospital, institution, or street address where death occurred:.....
Now long in hospital or institution?.....

3. (a) FULL NAME Axel Anton Most

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
8. (b) Name of husband or wife Mabel S. Most
7. Birth date of deceased (mo., day, yr.) Oct. 9. 1868 8. (c) If alive, give age 59 years

8. AGE: Years 77 Months 1 Days 26 If less than one day hrs. min.

9. Birthplace Trondheim Norway
(Town, county, and state)

10. Usual occupation Ship master (retired)

11. Industry or business dredge

12. Name Unknown Most

13. Birthplace Norway

MOTHER FATHER 14. Maiden name Unknown

15. Birthplace Norway

16. Informant William W. Most

Address Delaware City Del.

17. Burial Cemetery or crematory Balt

Location " Ma.

18. Funeral director William Cook Inc

Address 1217 St. Paul St.

19. (Date rec'd by registrar) 12/5/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Queen Anne's
City or town Love Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number 100

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1945 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1, 1945, to Dec. 5, 1945, and that I last saw him alive on December 4, 1945.

Immediate cause of death carcinoma of esophagus
Due to: and pharynx

Primary: carcinoma of pharynx
Due to: chemo.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Sept. 1941 Exploratory laparotomy
Date of op. Sept. 1941.

Autopsy results M. S. Tumors Hosp. Baltimore

PHYSICIAN: Please underline the cause to which death should be charged statitically.

22. VIOLENCE: If death was due to external causes, tell to the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodor Sattelmair M.D.
Address Stevensville
M. D. or other
Date signed 12/5/45

Evidence for the change of date of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

12654

FILM No. I 01 APR 3, 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Baltimore
City or town Chester
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Baby Person4. Sex male 5. Color or race B 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age..... years

8. AGE: Years 1 Month Days If less than one day about 1 hr. min.

9. Birthplace..... (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Benjamin Person13. Birthplace Baltimore14. Maiden name Thelma Landrum15. Birthplace Baltimore16. Informant Benjamin PersonAddress Chester md17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec 21, 1945

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Dec. 2 A 1945 (Date rec'd by registrar) L.C. Thomas (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Chester rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21, 1945 at.....

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

..... to
and that I last saw him alive on

Immediate cause of death.....

This baby was about one hour old when it died

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Harriett Stansbury midwife M. D. or otherAddress Stevensville md Date signed Dec 23, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ATTACHED TO THIS TELETYPE MESSAGE

NOT TO BE STAMPED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

655

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County

City or town

Queen Anne

Ruthsberry

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John B. Robinson

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

John B. Robinson

5. (c) If alive, give age

years

7. Birth date of deceased (mo. day, yr.)

Sept 30-1865

8. AGE:

Years
80Months
2Days
-It less than one day
hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

Edward Robinson

FATHER

MOTHER

12. Name

Edward Robinson

13. Birthplace

Dont Know

14. Maiden name

Emma Mildred

15. Birthplace

Dont Know

16. Informant

Mrs. John Robinson (wife)

Address

Centerville Md.

17. Burial

Date thereof Dec. 4, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Centerville Cemetery

Location

Centerville Md.

18. Funeral director

Edgar L. Lane

Address

Church Hill Md.

19. Dec. 3 1945

Edgar L. Lane

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Queen Anne

City or town

Ruthsberry

- (If outside city or town limits, write RURAL and give nearest town)

Street No.

-

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 1 1945 at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 27 1945 to Dec 1945

and that I last saw him alive on Dec 3 1945

Immediate cause of death

Hepatic Encephalopathy and

DURATION

Due to

Peritonitis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Henry Fisher

M. D. or other

Address

Centerville Md.

Date signed

RECEIVED

DEC 17 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12650

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
City or town Rural Centreville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? as his home

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

3. (a) FULL NAME

Jessie Smallwood

4. Sex Male 5. Color of face Colored 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Emma Jane Smallwood

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age. 1868 years

8. AGE: Years 77 Months Days If less than one day hrs. min.

9. Birthplace near Centreville 20. Co. Md.
(Town, county, and state)

10. Usual occupation Farm laborer

11. Industry or business

MOTHER FATHER Henry Smallwood

13. Birthplace in Centreville, Maryland

14. Maiden name Mary Nichols

15. Birthplace Queen Anne Co. Maryland

16. Informant Burley Smallwood

Address Rural Centreville, Maryland

17. Buried Date thereof Dec 30. 45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brownsville

Location near Centreville, Maryland

18. Funeral director Barton Bros

Address Centreville Maryland

19. 12-28-1945 Date rec'd by registrar Elie Demetroucq
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's

City or town Rural Centreville
(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 28 - 1945 at 3:45 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 28 1945 to Dec 28 1945 and that I last saw him alive on Dec 28 1945

Immediate cause of death:

Obster Pneumonia

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE:

W. Henry Fisher
M. D. or other

Date signed 12/29/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 870

CERTIFICATE OF DEATH

12658

Reg. Dist. No. 253

1. PLACE OF DEATH: *Stevensville*
County *Stevensville*

City or town *Stevensville* (If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death? *Entire life*
Hospital, Institution, or street address where death occurred:

Now long in hospital or institution?

3. (a) FULL NAME *Laura R. White*

4. Sex *Female* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Bernard White* 7. Birth date of deceased (mo., day, yr.) *Nov. 27 1877* 8. (c) If alive, give age *68* years

8. AGE: *68* Years *1* Months *24* Days *If less than one day* *hrs.* *min.*

9. Birthplace *Grace Md.* (Town, county, and state)

10. Usual occupation *At H.*

11. Industry or business

FATHER 12. Name *Jos. P. Moran* 13. Birthplace *Md.*

MOTHER 14. Maiden name *Annie Amelia Bright* 15. Birthplace *Md.*

16. Informant *Bernard White* Address *Stevensville Md*

17. Buried (Burial, cremation, or removal. Which?) Date thereof *Dec 26 1945* (month) (day) (year)

Cemetery or crematory *Stevensville* Location *Stevensville Md*

18. Funeral director *L. C. Thomas* Address *Stevensville*

19. (Date rec'd by registrar) *12/25/45* (Date signed) *12/25/45* M. D. or other *W. Chas. E. Payne*
Registrar *L. C. Thomas*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State *Md.* County *Stevensville*

City or town *Stevensville* (If outside city or town limits, write RURAL and give nearest town)

Street No. *—* (If rural, give LOCATION)

2. (a) If veteran, name war *—*

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 24 1945* at *10:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 20 to Dec 24 1945* and that I last saw her *alive on Dec 24 1945*

Immediate cause of death *Hypertension*

Due to *—*

Due to *—*

Other conditions *Acute Paralysis agitans*

(Include pregnancy within 8 months of death)

Major findings of operations *—*

Date of op. *—*

Autopsy results *—*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *—* Date of *—*

Where did injury occur? *—* (City or town) *—* (County) *—* (State)

Injured at home, farm, industry, public place (where?) *—*

Means of injury *—* Injured at work? *—*

23. SIGNATURE *W. Chas. E. Payne*

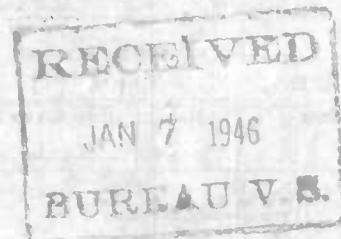
M. D. or other *—*

Address *Stevensville Md*

Date signed *12/25/45*

LEAD TO THE STATE OF UTAH

UTAH TO LEAD TO THE STATE



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

Reg. Dist. No. 253

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Queen Anne's
City or town Stevensville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Jabez Williamson

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

86 5 22 hrs. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

John Thomas Williamson

12. Name

MOTHER FATHER

13. Birthplace

Unknown

MOTHER

14. Maiden name

Sarah Ellen Lambert

15. Birthplace

Md.

16. Informant

Mrs. Norman S. Bryan

Address

Baltimore, Stevensville

17. Cemetery or crematory

Stevensville

Location

Stevensville, Md.

18. Funeral director

John J. Bryan

Address

Church Hill Burial

19. (Date rec'd by registrar)

19 X 5

(Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Eastport, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1945, at 10 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 21, 1945, to Dec. 22, 1945,

and that I last saw him alive on Dec. 22, 1945.

Immediate cause of death

Myocardial degeneration

Due to Coronary occlusion

Due to Senility

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

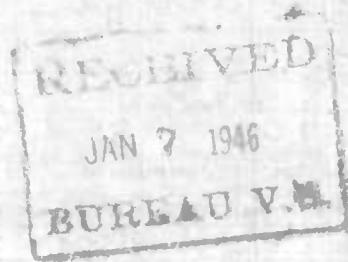
Injured at work?

23. SIGNATURE

Theodore Sattelmaier M.D.

M. D. or other

Address Stevensville Date signed 12/23/45



DEC 17 1945

BUREAU V-8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 326

CERTIFICATE OF DEATH

12560 251
Reg. Dist. No.

1. PLACE OF DEATH:

County: *Howard Co*City or town: *Ellicott City*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 weeks*Hospital, institution, or street address where death occurred: *No place*How long in hospital or institution? *No place*

3. (a) FULL NAME

4. Sex: *Male* 5. Color or race: *White* 6. (a) Single, married, widowed, or divorced: *Married*6. (b) Name of husband or wife: *Edgar L. Lane*7. Birth date of deceased (mo., day, yr.): *Nov 13 1875* 6. (c) If alive, give age: *100* years8. AGE: Years: *100* Months: *12* Days: *12* If less than one day: *hrs. 00 min. 00*9. Birthplace: *Baltimore Md.* (Town, county, and state)10. Usual occupation: *Legislator*11. Industry or business: *Legislator*12. Name: *Edgar L. Lane*13. Birthplace: *Baltimore Md.*14. Maiden name: *Edgar L. Lane*15. Birthplace: *Baltimore Md.*16. Informant: *Ellicott City Md.*Address: *Ellicott City Md.*17. Burial: *Burial* Date thereof: *Dec 28 45* (Burial, cremation, or removal. When?) (month) (day) (year)Cemetery or crematory: *Centreville Cem.*Location: *Centreville Md.*18. Funeral director: *Edgar L. Lane*Address: *Church Hill Md.*19. Date rec'd by registrar: *Dec 25 45* 19 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: *Howard Co*City or town: *Ellicott City*

(If outside city or town limits, write RURAL and give nearest town)

Street No.: *No place*

(If rural, give LOCATION)

2.(a) If veteran, name war: *None*3. (b) Social Security Number: *None*

MEDICAL CERTIFICATION

20. DATE OF DEATH: *December 24 45*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 20 45 19 to *December 24 45* 19 and that I last saw him alive on *December 24 45*Immediate cause of death: *Heart Disease*Due to: *None*Due to: *None*Other conditions: *Coronary Disease*

(Include pregnancies within 8 months of death)

Major findings of operations: *None*Autopsy results: *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: *None*Where did injury occur? *None*

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury: *None*Injured at work? *None*23. SIGNATURE: *Edgar L. Lane*Address: *Ellicott City Md.*Date signed: *Dec 25 45*

M. or other

